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Exploring the Effectiveness of Family Planning & HIV Integration in Jamaica

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Abstract

Exploring the Effectiveness of Family Planning & HIV Integration in Jamaica

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This paper aims to examine the integration of Family Planning and HIV services within the Jamaican context by exploring the main challenges associated with integration and highlighting some of the approaches used to address these challenges. Perspectives were sought on integration of Family Planning and HIV integration from participants who were selected from a cadre of Jamaican health care providers. Data collection was done using a mixed methods approach, incorporating both qualitative and quantitative methods. Methods included a key informant interview, document review and an online questionnaire of healthcare providers. Findings reveal that successful integration increases cost savings and expansion in service delivery

however weak legislative frameworks and funding issues where found to challenge successful integration. Implications for policy were discussed as they related to the development of a legislative framework, funding and human resources. Recommendations were made for further studies.

Key words: integration, healthcare delivery, Family Planning and HIV, Jamaica

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List of Abbreviations and Acronyms

AIDS	Acquired Immune Deficiency Syndrome
CHART	Caribbean HIV/AIDS Regional Training Network
CHLI	Caribbean Health Leadership Institute
FP	Family Planning
GNP+	Global Network of People living with HIV
HIV	Human Immuno-deficiency Virus
ICW	International Community of Women Living with HIV/AIDS
IPPF	International Planned Parenthood Federation
JNFPB	National Family Planning Board
MAP	Multi-country HIV/AIDS Program
MDG	Millennium Development Goals
MOH	Ministry of Health
NHP	National HIV/STI Programme
PEPFAR	President's Emergency Program for AIDS Relief
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
RHA	Regional Health Authority
SRH	Sexual Reproductive Health
STI	Sexually Transmitted Infections
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Fund for Population Activities
UNGASS	United Nations General Assembly Special Session
UNPF	United Nations Peace Forces
WHO	World Health Organisation

I. INTRODUCTION

The World Health Organization (WHO) reports that 498 million people are infected each year with a sexually transmitted disease while 34 million people worldwide were living with AIDS in 2011 (WHO, 2013).These figures are disturbing especially in light of the fact that there is greater worldwide awareness of the modes of transmission and methods of prevention of sexually transmitted diseases. As such the call for the integration of HIV and Family Planning services has become more strident as it is seen as an important step in achieving international development goals and targets, including the United Nations Millennium Development Goals. Additionally the benefits to be derived from this integration can be seen in practical ways. The WHO in a 2009 review found that by integrating Family Planning and HIV-related policies and programmes a number of important public health socioeconomic and individual benefits could be had. The report noted that as a result of this integration there was both improved access to and uptake of key HIV and Family Planning services; reduction in HIV-related stigma and discrimination, better utilization of scarce human resources for health, improved quality of care, improved coverage of underserved/vulnerable/key populations and decreased duplication of efforts and competition for resources (WHO et al.,, 2009).

This paper aims to examine the integration of Family Planning and HIV services within the Jamaican context. It explores the main challenges

associated with integration and seeks to highlight some of the approaches used to address these challenges by inter-governmental organizations/ non-governmental organization as well as other developing countries. Finally this research concludes with recommendations to facilitate the successive integration of Family Planning and HIV services in Jamaica. This is important to Jamaica as we strive to curb the spread of HIV and reduce the number of unplanned pregnancies by expanding the healthcare access to the wider population.

Jamaica like other countries has not been spared from the deleterious effects of HIV/AIDS. In fact since the first incidence of the disease some thirty years ago a total of 27,272 persons were reported to have contracted HIV/AIDS in Jamaica with a cumulative number of reported AIDS deaths totalling 8,102 for the period 1982 – 2010 (UNAIDS, 2012). Reports also indicate that of the approximately 32,000 persons living with the disease in 2010, less than half are aware of their status. Additionally, there were a total of 25,557 new STI patients reported for the same period (Ministry of Health, 2010).There are a number of underlying socio-economic and cultural factors that drive the HIV epidemic in Jamaica. According to (Figueroa, et al., 2008) sexual and mating patterns are deeply ingrained in the Jamaica culture as are gender roles and expectations associated with sexual practice.

In addition to these startling HIV statistics the reproductive health situation of Jamaica is also of concern. A 2008 Reproductive Health Survey (RHS) report highlighted that as much as 47% of all births in Jamaica were unintended and

that there were high incidences of adolescent pregnancy and the related trend of adolescent girls who are infected with HIV. Additionally the report highlighted that the median age at first intercourse for females 15-17 is 14.4 and for those aged 18-19, the average age is 15.8, and that the percentage of women aged 15-19 who have ever had sexual intercourse, is 43.6%.These facts are alarming when coupled with the findings of the 2008 Knowledge Attitude and Practices Survey which points to a high level of sexual risk-taking among young girls aged 15-24 years. Just over 20% (21.4%) of females aged 15-24 years old reported having more than one sexual partner within a 12-month period(Serbanescu, Ruiz, & Suchdev, 2010).These statistics present a compelling argument for integrating Family Planning and HIV services. This integration would serve to address the needs of the sexually active population of Jamaica more comprehensively than the current independent family planning and HIV programmes.

The Government of Jamaica in turn began to heed this call for HIV and Family Planning service integration. In 1993 the decision was made to integrate HIV and Sexually Transmitted Disease prevention into all clinical and community services by the then Jamaica Family Planning Association (JFPA). Since then further attempts have been made to advance this integration, however it was not until international donor agencies began to promote the establishment of a single authority charged with the responsibility for HIV management as a prerequisite for HIV assistance and donor funding in 2010 that the integration process gained traction.

The call for the integration of Family Planning and HIV services was one which was first mooted in 1994 at the International Conference on Population and Development held in Cairo. This conference sought to highlight the need for universal access to health services as a means of halting the spread of Sexually Transmitted Infections (STIs) in general and HIV in particular. Since then there has been wide consensus from organizations such as the World Health Organization (WHO), the United Nations Population Fund (UNFPA), United Nations Programme on HIV/AIDS (UNAIDS), United Nations General Assembly Special Session on HIV/AIDS (UNGASS) and the African Union to suggest the importance of linking Family Planning (FP) and HIV/AIDS policies, programs and services.

It should be noted that despite the strident calls for integration since the Cairo conference there has been to date no defined system in place to explicitly promote, monitor or indeed to define what is meant by 'integrated reproductive health services'. This has led to countries either avoiding the integration of reproductive health services or developing their own sense of what these services should mean.

The basis for HIV and Family Planning integration is one that becomes obvious when we consider that '…integrated services are thought to expand access to and coverage of critical services and to improve their efficiency and cost effectiveness by reducing duplication of service delivery functions and delivering more services per client contact' (Hardee & Yount, 1995). Additionally (Lush, 2002) argues that sexually active women are at risk for

both unplanned pregnancies and HIV, and therefore through the integration of these two services the associated risks are mitigated and result in both the prevention of new HIV infections and prevention of unplanned pregnancies. Lush's argument is given credence when the HIV situation is examined in Sub-Saharan Africa-the region with the highest HIV incidence-and find that women of reproductive age are disproportionately affected by the HIV/AIDS epidemic, and account for almost 60% of people living with HIV(UNAIDS, 2008).

Rationale & Objectives

Important reports/policy statements have sought to emphasize the synergy that exists between HIV services and family planning by highlighting the wide-ranging health and social benefits of integrating these services. When examined from a Family Planning perspective we see the importance of integrating HIV services into family planning programs. Millions of women at risk of HIV—as well as those living with the disease but unaware —come into contact with the health care system, either within clinical settings or through community-based programs, seeking to prevent unintended pregnancy. Their interaction with family planning providers is an opportunity to receive HIV prevention information, counselling and testing, and referrals for care and treatment as appropriate.

From the standpoint of HIV programmes the benefits of integration are also identifiable. A substantial number of HIV-positive women in HIV care and treatment programs or prevention of mother-to-child transmission (PMTCT) programs experience unplanned pregnancies. Examples of this can be found in several studies conducted in Sub-Saharan Africa and suggest that the proportion of pregnancies that are unintended among HIV-positive women in HIV programs range between 51% and 92% (Halperin, Stover, & Reynolds, 2009). As such, making contraceptive services more widely available through HIV care, treatment and PMTCT programs would make it easier for these women to coordinate their HIV-related care with their pregnancy prevention goals, and at the same time, help prevent mother-to-child HIV transmission.

It is with this background that the Jamaican Government began examining the practicality of integrating the Jamaica National Family Planning Board (JNFP) and the National HIV/STI Programme (NHP). This examination is being undertaken with the background that the mandates of the bodies in question are different. The JNFP is mandated to undertake and promote sustainable family planning services whilst the NHP's mandate is to reduce the transmission of HIV infections through the coordination and implementation of the national HIV/AIDS response.

In examining the effectiveness of integrating HIV and Family Planning Programmes within the Jamaican context this research will, (a) inform strategic decision-making towards integration and (b) assist the Ministry of Health in its approach and strategy towards integration.

Objectives

1. To outline common international HIV and Family Planning integration frameworks
2. To explore the concept of integration of HIV and Family Planning within the Jamaican context
3. To assess which factors contribute to successful HIV and Family Planning integration in general and in the Jamaican context

4. To assess international best practices and provide recommendations of strategies to overcome the challenges faced in the Jamaican scenario

The notion of HIV and Family Planning integration is not necessarily a new concept to Jamaica. It can be traced back to 1993 when the Jamaica Family Planning Association, the predecessor to the JNFP sought to integrate HIV and STD prevention into all its clinical and community services. Thus the integration has formed a part of the process of health service reorganization that has been undertaken for upwards of three decades. Unfortunately full integration has not been realised. This un- realization of integration can be attributed a number of reasons as cited by Brathwaite,(2001) who posits that there are many challenges to HIV and Family Planning integration, most of which he feels stem from the historical development of the two program areas as separate entities. He further argues

> '…while the Ministry of Health (MOH) has accepted integration of the health services as a policy, continued perception of the separateness of HIV/STI and FP programs means that integration at the field level has been slow. Other challenges stem from the subject area and the fact that many health providers, even after "medical training" remains uncomfortable with their own sexuality and the sexuality of adolescents. Attempts to compensate for this may result in avoidance of the subject matter or in crude attempts at humor or braggadocio' (Brathwaite, 2001).

Brathwaite also sites provider or client attitudes, lack of resources, or service or policy related issues as further reasons for the failure of integration.

While the integration process is not new it is important to understand what exactly is meant by integration of Family Planning and HIV services. Integration of Family Planning and HIV services refers to '… combining components of Family Planning /Reproductive Health and HIV services that are currently separate, with the goal of maximizing coverage and health outcomes for the client and optimizing the wise use of scarce resources (Population Reference Bureau, 2009).'

Methodology

The methodology to which I ascribe to this research is one which utilizes deductive reasoning to explore and explain policy integration. Deduction as defined by Babbie refers to the '…logical model in which specific expectations of hypotheses are developed on the basis of general principles' (Babbie, 2012).

To meet the objectives of this research literature review of both peer-reviewed and grey literature was conducted. This included searches using ProQuest, JSTOR, PubMed and Google Scholar focusing on key words: health integration, integration, implementation health system, integrated services, integration of Family Planning and HIV services, stigma and discrimination, and interventions to reduce stigma and discrimination. To ensure a comprehensive literature review, no date restrictions was put on the search.

Further papers that included program evaluation reports, white papers, and presentations identified through searching the websites of organizations involved in Family Planning and HIV service provision including the World Health Organization (WHO), United Nations Children's Fund (UNICEF), United Nations Program on HIV/AIDS (UNAIDS), and Family Health International (FHI) and Population Reference Bureau (PRB) were reviewed.

Following the literature review an interview schedule was designed by the researcher based on the findings unearthed from the literature review. The interview schedule was administered to key stakeholders. Additionally a

questionnaire was selected and sent via email to 108 healthcare providers in Jamaica. The results of both the documents along with the findings from the literature review were used to answer the research question.

II. LITREATURE REVIEW

Theoretical Framework

It must be recognized that policy-making is a multifaceted process requiring scientific knowledge as well as interests, values, established positions within institutions, and personal ambitions. Integration has been implemented through various theoretical frameworks. Two such frameworks that can be used to address the issue of integration are Rational Planning and Incrementalism.

Rational planning is an approach to problem-solving and decision making that is deliberate, thorough and provides a structure for the kind of critical self-assessment necessary when addressing complex issues. The concept of rational planning can be attributed to Herbert Simon (1960) whose administrative rational model of organization is frequently identified as a generic approach applicable to either government or corporate enterprises.

Rational Planning endeavours to describe a process of efficient decision making. Decision making is seen as a rational, linear process that will produce rational outcomes. It typically includes the stages of clarifying and ranking goals, identifying an array of alternatives for reaching the goals, predicting the consequences of each alternative, comparing the anticipated consequences of the various alternatives and selecting the alternative that maximizes the attainment of goals. If policies do not achieve what they are intended to achieve, blame is often not laid on the policy itself, but rather on political or

managerial failure in implementing it (Juma & Clark, 1995). Failure can be blamed on a lack of political will, poor management or shortage of resources.

Rationalism has been criticized for being unrealistic in terms of information and analytical requirements and unable to deal with situations in which goals are unknown or in dispute. It treats decision making as an intellectual process rather than a political one. Forester posits in his critique of rational planning that it neglects essential characteristics of real-world decision-making situations, namely the fallibility of human comprehension ability, the limitation in resources, time, and access to information, the multiplicity of competing rational actors and power structure imbalance (Forester, 1989). Another criticism levelled against rational planning theory is that it is beyond the scope of human cognitive ability and institutional, technical and organizational capacity because humans cannot comprehend everything nor can they even fully comprehend one planning aspect (Lindblom C. , 1959). They tend to rely on simplification of intricate issues to reach satisfactory decisions rather than optimal solutions, based on which process important possible outcomes, alternative potential policies, and affected values are often neglected or overlooked (Lindblom C. , 1959). Rational Planning has further been criticised for what has been referred to as a "one strategy fits all" approach to decision making which is said to hinder its ability to incorporate the diversity of perceptions, interests, and values into a single plan (Abukhater, 2009).

From the literature it would appear that rational planning is most often used in the areas of urban planning (Larsen, 2003; Pasour, 1983; Betraud & Renaude, 1997), transportation (Willson, 2001; Innes & Gruber; 2005, Black, 1990) and forestry (Lane, 1999; Weinberg, 1971; Schanz, 2002). Unfortunately there is little evidence of its use in the health care sector and more so as it relates to policy and policy integration in this area. However this does not mean that the governing principles of rational planning cannot be applied in that context. The applicability of rational planning principles is evidenced through a study carried out by Wang & Hoch (2013). These scholars examined the disparate institutional planning systems in Chicago in the United States and Shanghai in China and found that despite the many differences that existed-politically, technically, and in there institutional design and ideology-there remained a shared commitment to the doctrine of rational planning (Wang & Hoch, 2013). The scholars point out that

> '…in Shanghai, the planners believe that public benefit flows downward from regional priority to district project. They emphasize the production of layered plans across scale offering increasing levels of detail. Policy flows rationally from center to periphery and from plan to place—oftentimes leaving little room for the benefit of local feedback and intelligence. Planners possess the authority to represent interests abstractly and legitimately. In Chicago, the planners believe public benefit emerges through layers of planning compromise tied to networks of political involvement. Policy emerges across scale laterally through collaboration as multiple plans proposed by different

> institutional actors compete for validity and legitimacy. Planners identify and mobilize agreement among plans across scale and political interest. Shanghai planners enjoy authority but suffer the limits of a one-way rationality. Chicago planners lack strong authority but enjoy the resilience of adaptive collaboration among competing economic and community actors' (Wang & Hoch, 2013).

However despite these differences planners in in these two cities continue to use the same rational planning doctrine to describe and organize the work they do. According to Hoch (2002) they use the rational planning model to combine knowledge, values, and interests to make plans that offer the promise of persuasion for different stakeholders and actors in their respective settings (Hoch, 2002). In integrating these two entities we would naturally expect to be combining knowledge, values and interests of these different stakeholders and the Chicago Shanghai experience helps to inform the process for integration of HIV and Family Planning services in Jamaica. This is so, as when we look at the experience of Chicago and Shanghai with their divergence across generations and neighbourhoods, among disparate ethnic groups and migration flows and between civic association and government decision making, the application of rational planning methods to achieve their urban development goals forms the foundation through which programme success was achieved.

Incrementalism as theorised by Charles Lindblom is a policy-making process that produces decisions that are only marginally different from past practice.

Incrementalism implies that no more than small or incremental steps are ordinarily possible. One of the tenets of incrementalism is that small steps add up over time and can result in important changes in policy and process. On the other hand, the speed of change can be frustratingly slow – for the reason that small steps do not upset the democratic 'applecart'; big steps do (Lindblom C. , 1979).

Common areas of critique of this framework include 1) difficulty in analysis and limitations in its use and application 2); considered overly conservative in its approach resulting in constrained innovation; 3) seemingly au fait with the status quo by the very nature of the small incremental steps taken to introduce change and 4) insufficiently proactive, goal oriented, and ambitious (Arrow 1964; Etzioni 1967; Dror 1964; Dror 1969; Lustick 1980).

Other authors in their analysis of incrementalism have countered these criticisms. In refuting the claim that incrementalism is passive and hinders the active pursuit of goals Quinn, posits '…in the hands of skilful executives, ...incrementalism can be a purposeful, powerful management technique for integrating, analytical, behavioural, political and timing aspects of strategy formulation' (Quinn, 1982). The criticism of incrementalism's limited applicability especially in periods of crisis is countered by Hayes,1987 who asserts that even dramatic, rapidly escalating issues often fail to yield non-incremental policy outcomes, and '…incremental outcomes may be likely under a wider range of conditions than previously thought' (Hayes, 1987).

Incrementalism as a framework presents an approach that is less risky as it affords policy-makers the ability to address complex issues incrementally. It provides policy-makers an opportunity to make decisions by evaluating the best options available in keeping with limitations of time and resources. Policies are pursed step by step and are adjusted as necessary on the basis of whether or not the intended outcomes are being achieved. Incrementalism allows decisions to be made with reflection on the past with gradual change taking place in accordance with the realities of the given circumstances.

The incrementalist approach allows for a greater role for interests in policy-making and emphasises the many sources of information that impinge on policymakers. As such the use of this approach has been found in a number of areas including education (Wurth, 1973; Evans & Henrichsen, 2008; Lungu 1985) finance (Wu, 1981; Bramley 1985) and health (Sparer, France & Clinton, 2011; McCanne, 2003; Shi & Douglas, 2005). These scholars use the incrementalist approach to highlight how both the development and implementation of policy is achieved through the slow evolution of existing policy to expand the original intent of a policy. Through the use of the incrementalist approach policy makers are able to review a small number of alternatives for dealing with a problem and then to choose options that differ only marginally from existing policy.

Perhaps the clearest example of the incrementalist approach to health policy is that of the America health care system. Shi &Singh (2005) opined that health policies in the United States have been incremental and piecemeal and as

evidence point to the gradual reforms that have taken place since the establishment of Medicaid program in the 1960's (Shi & Singh, 2005). They argue that the changes made to the Medicaid program serve to illustrate how a program is reformed and/or expanded through successive legislative enactments over several years. Shi &Singh posit the effectiveness of the incremental approach to health policy by arguing that

> '…innovative, non-incremental policies are resisted by the established groups because such measures undermine the bargaining practices designed to reduce threats to established interests. The stability of the system is ensured because most groups are satisfied with the benefits they receive; however, the result for any single group is less than optimal' (Shi & Singh, 2005).

Incremental policy-making is essentially remedial, focusing on small changes to existing policies rather than dramatic fundamental changes. Incorporating this approach within the Jamaican context of HIV and Family Planning policy integration would seem to facilitate the necessary changes to Jamaica's existing vertical health policies and transforming them in to an integrated policy.

This research is based on the theoretical underpinnings found in incrementalism and that of rational planning. In Jamaica the endeavours at integration over the past 30 years has noted the efforts of building on previous iterations thereby providing a ready platform for the incrementalist approach. The use of the rational planning approach on the other hand will allow us to

examine the integration approaches available enabling us to compare and select the alternative that best suits the attainment of goals.

It is important to point out that introducing a completely new approach to integration may not be feasible within the Jamaican context in light of the country's dire economic situation and historical and current political approach to policy development. This study will be gathering information from key personnel within the health field to identify their perceptions of what exists and the requisite add-ons that would make for productive and holistic integration of HIV and Family Planning services. It may be argued that this current iteration of integration has been impacted by internal and external forces including but not limited to the efforts of the Jamaican government to reform its public sector as well in agreement with the UNAIDS "Three Ones' principle.

Theoretical Issues

What is Integration?

When the concept of integration is examined we must first look at what scholars have defined the term to mean. Scholars such as Meijers and Stead define the term in the context of policy integration and argue that it concerns the management of cross-cutting issues in policy-making that transcend the boundaries of established policy fields (Meijers & Stead, 2004). Underdal reinforces this view when he posits '…the basic requirements for policies to be qualified as 'integrated' are comprehensiveness (recognizing a broader scope of policy consequences in terms of time, space, actors and issues), aggregation (a minimal extent to which policy alternative are evaluated from an 'overall' perspective) and consistency (a minimal extent to which a policy penetrates all policy levels and all government agencies) (Underdal, 1980).

Healthcare Integration

As we begin to glean an understanding of the term integration we must then shift our focus to understanding what the term means within the context of health services. In the *Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages: A Generic Guide,* developed by IPPF, UNFPA, WHO, UNAIDS, GNP+, ICW, and Young Positives, integration is said to mean '…combining different kinds of reproductive health and HIV services or operational programs to ensure and maximize collective outcomes. It would include referrals from one service to another and is based on the need to offer comprehensive services. Integration refers exclusively to health

service provision and is therefore a subset of linkages' (Family Health International , 2010). Integration in the context of health is further defined as '…offering two or more services at the same facility during the same operating hours, with the provider of one service actively encouraging clients to consider using the other services during the same visit in order to make those services more convenient and efficient (Henry Shears, 2004) .

If we drill down further to ascertain the meaning of integration with respect to HIV and Family Planning services we see where scholars posit that this type of integration means '… combining components of Family Planning / Reproductive Health and HIV services that are currently separate, with the goal of maximising coverage and health outcomes for the client and optimising the wise use of scarce resources' (Ringheim, Yeakey, Gribble, Sines, & Stepahin, 2009).

Benefits of Integration

As was noted earlier, the integration of Family Planning and HIV services is not a new phenomenon and it has in fact been implemented in many countries around the world. Prior studies have found that there are many benefits to be had by integrating Family Planning and HIV services (Cates and Stone 1992; Pachauri 1994; Mayhew 1996; Shelton 1999; Askew and Berer 2003; Berer 2004; Mitchell et al. 2004; UNFPA 2004a; WHO 2004; WHO et al. 2005). These studies have indicated that a number of positive benefits can be realised through the integration of Family Planning and HIV services.

An increase in client satisfaction has been found to result from integration. This has been said to occur as a result of the ability of clients to access a wider range of services from a single clinic visit. Church and Meyhew in their research found that through integration of services, client satisfaction within the target population increased as clients were able to access both family planning and HIV services at one appointment rather than going to two(Church & Mayhew, 2009). This has meant that through combined services, service providers were now in a better position to access a wider population and provide an increase in the range of care through cross-utilization of services and reduced need for referrals. These findings were concurred by Askew and Berer in their research however they noted that risk assessment of sexual behaviour was necessary prior to the integration of STI/HIV into Family Planning services (Askew & Berer, 2003). Other research on client preferences has found that women prefer to access reproductive health and HIV-related services from the same health centre (Family Health International, 2007), (Mullick, Menziwa, Mosery, Khoza, & Margoa, 2008). It is important to note that while client satisfaction is achieved with service integration, pitfalls may also occur. Scholars note that integrating health programs can have the positive effect of improving the quality of care by increasing the breadth of care provided or it can have the opposite effect of diminishing quality as breadth is achieved at the expense of depth (Kane & Wellings, 1999).

Integration of Family Planning and HIV services has also led to an expansion in access to service for underserved populations. A 2009 Population

Reference Bureau policy brief of integration strategies in Ethiopia, Kenya, Lesotho and Uganda cited that of the more than 200 million women with an 'unmet need' for family planning included women who were either already HIV positive or at risk for HIV. Further in a five-country study among women attending HIV counselling and testing centres, 15% to 67% of all women (HIV positive or negative) were identified as having an unmet need for family planning (Admachak & al., 2009). In response to this the President's Emergency Plan for AIDS Relief (PEPFAR), which represents that United States government's primary initiative to combat global HIV and AIDS authorized legislation to support the integration of these services as a means of helping to prevent new HIV infections, better satisfy unmet demand for Family Planning and improve the health of women, men and children (Population Reference Bureau, 2009).

It has been posited that family planning and reproductive health providers are resistant to integration as they fear that this integration would encourage and attract the underserved populations – men, sex workers and People Living With HIV (PLWH). Church and Mayhew argue however that these fears are baseless; rather their findings suggest that while the success of Family Planning and HIV service integration is mixed for non-traditional clients, it is attributable to variations across country and different programme designs (Church & Mayhew, 2009). Integration has also served to address the needs of sex workers who would otherwise not have access to care. In Ghana, an outreach project with sex workers was combined with a facility-based service in public health clinics offering STI and HIV services. Sex workers' use of

facility services more than doubled during a three-year period and condom sales rose from 300,000 to 2.5 million during a five-year period at no detriment to the existing client load (PATH, 2005).

The reduction in stigma and discrimination and breaches in confidentially among HIV populations is another factor that has been attributed to Family Planning and HIV integration. Stigma and Discrimination faced by members of the HIV population from health-care personnel has long been documented (Thorburn Bird et. al 2004; Reis et.al 2005; Kinsler et. al 2007; Cannon Poindexter 2013). It is in light of this that concerns were raised as far back as the 1990s that integrating Sexually Transmitted Infection (STI) services with Family Planning services would be stigmatizing for clients needing to utilize STI services. Additionally it was felt that providers of family planning services would find it difficult to address the needs these higher risk clients (Mayhew, 1996). However contrary to this, numerous research have dispelled this notion and Church and Mayhew offer findings from their research provided no correlation between integrated services increasing stigma towards services or clients, rather integrated services offered a less stigmatizing environment than those not integrated with Family Planning services (Church & Mayhew, 2009). These findings are supported by other research that found that traditional clients did not experience increased apprehension by the attendance of more diverse clients who included men and sex workers (Rob, 2005).

Integration of Family Planning and HIV services has also proved beneficial with respect to the impact of HIV on maternal and child health. Scholars note that the reduction of HIV infection in infants could not be met through a focus on prevention of transmission from mother to infants alone. Rather they posited that greater emphasis was needed to prevent infection in women of reproductive age, helping women living with HIV to know their status and avoiding unintended pregnancies (Stover, 2003). This argument was supported by other research that suggested that by adding family planning to on-going services for the prevention of HIV transmission could, by preventing unwanted pregnancy, double the number of HIV positive births averted (Sweat, 2004). Further evidence to support the positive impact that Family Planning and HIV service integration played on maternal and child health was made in 2001 at the UN General Assembly's 26th Special Session (UNGASS) Declaration of Commitment on HIV/ AIDS. It was during this session that the achievement of prevention of mother-to-child HIV transmission targets was linked to the delivery of an integrated set of interventions, including antenatal care, HIV testing and counselling, HIV-related care, treatment and support services, and appropriate sexual and reproductive health services across the wider health sector (UN General Assembly Special Session on HIV/AIDS (UNGASS), 2001).

Another benefit to be derived from the integration of Family Planning and HIV services are the savings achieved from the integration. Research supporting these findings suggests that the cost-effectiveness of integration include the potential to maximize productive use of scarce resources and

reduce inefficiencies such as duplication of service delivery functions (Foreit, Hardee, & Agarwal, 2002). Integration has also resulted in cost savings through the sharing of staff, facilities, equipment as well as administrative and overhead costs (Askew & Berer, 2003). Savings resulting from integration have not been the sole purview of providers, as from the client perspective integration was found to be cost-effective by reducing the frequency of visits to health facilities which in turn reduced the cost of related appointments (Ringheim, Yeakey, Gribble, Sines, & Stepahin, 2009).

While there has been research that points to the cost-effectiveness that result from integration, there still appears to be caveats to this view. Scholars have cited the need for service providers to have sufficient time prior to service integration commencing in order for cost-effectiveness or improved productivity to be achieved after the addition of new services (Foreit J. , 2006) (Janowitz, Johnson, Thompson, West, Marangwanda, & Baker Maggwa, 2002). Additionally, other research focusing on the cost-effectiveness of integrating HIV services with other health services found that while studies on integration of family planning for HIV positive clients found provision of family planning to be highly cost-effective or cost-saving relative to non-integration, none compared unit costs of integrated HIV/FP care and treatment versus stand-alone services, nor examined comparative costs of different integration models and so this area needed to be further examined (Sweeney, Obure, Maier, Greener, Dehne, & Vassall, 2012).

Challenges of Integration

It must be noted that whilst there are benefits to be had from the integration of Family Planning and HIV services scholars have also identified a number of challenges that can result. Scholars articulate that '…integrated services are thought to expand access to and coverage of critical services and to improve their efficiency and cost-effectiveness by reducing duplication of service delivery functions and delivering more services per client contact'(Hardee & Yount, 1995). However it has been argued that in order to achieve these goals there must be a concerted effort to address the political, financial and managerial constraints that implementing integration would have on countries and especially low-income countries.

Lush is her research alludes to the fact that one of the first challenges facing countries, especially low-income ones as they embark on integration is the difficulty in defining integration and what it should look like in their specific country setting. She points to three issues to consider, first is the fact that integration may vary by type of facility. It may be feasible to integrate family planning and HIV services in urban settings but providing those same integrated services in rural settings may not be feasible. The second issue to consider according to Lush revolves around the variety that obtains at the administrative level which may inhibit integration. She posits '…it is important to distinguish between functional integration (i.e., the ultimate goal of providing holistic, integrated services to clients) and administrative integration, which may be desirable but is probably not necessary to ensure functional integration' (Lush, 2002). Lush's final consideration is the

appropriateness of integration which she states should be dependent on the prevalence of disease and the country situation. This assertion is supported by other scholars who note that in localities with high incidence of HIV, mass treatment may be the most cost-effective approach; while in areas of low-prevalence targeting high-risk groups may be more suitable (Pachauri 1994; DeLay 1994; Meda 1995).

Other challenges have been highlighted in the quest to achieve Family Planning and HIV service integration. Perhaps the most pressing of which is the difficulty in delivering family planning in a cohesive manner which serves both the needs of the users and donors because of funding. It must be understood that in many low-income countries, programmes offering Family Planning or HIV services are usually implemented in response to donors' wishes (e.g. UNAIDS, PEPFAR, and the Multi-Country HIV/AIDS Program [MAP]). These programmes are usually easier for local health ministries to manage because they are separate entities, and the administrative and medical personnel are trained for specific tasks. However, according to one scholar '…the down side of those programmes is that they often strain health systems by employing the same medical personnel and utilising the same state health and laboratory facilities' (Maynard-Tucker, 2009).

Evidence suggests that global funding trends have been slow to reflect the high level of policy support in favour of integrating HIV/Family Planning services, which has become a key obstacle to wide-scale implementation of contraception as an HIV-prevention strategy. Key donor institutions such as

PEPFAR and the Global Fund have been equally slow to relinquish the vertical orientation of funding mechanisms for HIV and reproductive health, which in turn has impeded efforts to integrate these services (Johnson, Varallyay, & Ametepi, 2012). The point is supported by another scholar who posits '…for individual women who live where HIV is rampant, the interrelatedness of HIV prevention and unintended pregnancy prevention is a practical reality. Yet most international program donors, including the United States government, have viewed them as complementary goals but separate and unrelated outcomes' (Cohen, 2008).

The Kaiser Network in their 2008 report on integration of family planning, reproductive health and antiretroviral service and its link to the reduction in HIV/AIDS cases in Africa noted that an integrated approach of implementing Family Planning along with counselling and services in public-sector HIV/AIDS programmes would address many social problems (e.g. stigma and discrimination), and would increase efficiency of the services and convenience for patients. They however caution that this approach would be difficult to achieve for a number of reasons. They cited lack of sustainable funding, limited numbers of competent medical staff, increased workloads, and lack of dual-protection promotion in rural regions, along with inadequate male involvement in Family Planning as compared to women as just some of the challenges that may be faced when integrating. With respect to developing countries, integration of health services has been argued against as it has been suggested that the health system is not sufficiently strong to support efforts to integrate services. Further it has been argued that effective

integration of services within developing countries can be constrained as they suffer from fragile health systems, particularly in terms of logistical challenges and health workforce gaps (Kuhlmann, Gavin, & Galavotti, 2010).

There have been various calls for the integration of Family Planning and HIV services for a number of years beginning with the 1994 U.N. International Conference on Population and Development Programme of Action which highlighted that prevention and treatment of HIV were essential components in the provision of quality reproductive health care. This was followed up by the WHO and UNFPA 2004 Glion Consultation on Strengthening the Linkages between Reproductive Health and HIV/AIDS: Family Planning and HIV/AIDS in Women and Children or the Glion Call to Action, 2004 and the 2005 G8 Gleneagles Commitment, the UNGASS, 2006 Declaration of Commitment to HIV/AIDS and the 2006 African Union Conference: Maputo Plan of Action for the Operationalization of the Continental Policy Framework for Sexual and Reproductive Health and Rights: 2007–2010. All the conference and subsequent international agreements were aimed at highlighting that linkages between Family Planning and HIV services were both programmatically and medically sound as well as financially prudent.

Table 1- International Statements Supporting Family Planning and HIV/AIDS Linkages

International Statements Supporting Family Planning and HIV/AIDS Linkages	
Report or Policy	**Statement**
International Conference on Population and Development Programme of Action (UN, 1994)	Names prevention and treatment of HIV an essential component of comprehensive reproductive health care.
Glion Consultation on Strengthening the Linkages between Reproductive Health and HIV/AIDS: Family Planning and HIV/AIDS in Women and Children (WHO,UNFPA, 2004)	Recommends a course of action for governments, United Nations agencies, donors, nongovernmental organizations, and others to strengthen linkages between family planning and prevention of mother-to-child transmission of HIV (PMTCT) policies and programs.
Reproductive Health Strategy to Accelerate Progress towards the Attainment of International Development Goals and Targets (WHO, 2004)	Cites combating HIV as one of five priority aspects of sexual and reproductive health.
New York Call to Commitment: Linking HIV/AIDS and Sexual and Reproductive Health (UNFPA, UNAIDS, FCI, 2004)	Calls for an urgent effort to strengthen links between corresponding sexual and reproductive health and HIV policies, programs, and services.
2005 G8 Gleneagles Commitment (UNAIDS, 2005)	Describes integration with sexual and reproductive health as important in achieving the G8 commitment to reach universal access to HIV prevention, care, and treatment.
Intensifying HIV Prevention (UNAIDS, 2005)	Names integration an essential policy action for HIV prevention.

Declaration of Commitment to HIV/AIDS (UNGASS, 2006)	Challenges the global health community to forge closer linkages between sexual and reproductive health and HIV through better policy and program coordination
Maputo Plan of Action for the Operationalization of the Continental Policy Framework for Sexual and Reproductive Health and Rights: 2007–2010 (African Union, 2006)	Recommends integration of HIV/AIDS services into sexual and reproductive health services so that African countries can achieve universal access to sexual and reproductive health by 2015.
Guidance on Global Scale-Up of the Prevention of Mother-to-Child Transmission of HIV (IATT on PMTCT, 2007)	States linkages between PMTCT and sexual and reproductive health services are a key strategic approach to realizing comprehensive PMTCT services.

Adapted from and updated: Wilcher R, Petruney T, Reynolds HW, Cates W Jr. From effectiveness to impact: contraception as an HIV prevention intervention. Sex Transm Infect. 2008;84(Suppl2):ii54-60.

III. RESEARCH METHODS

In this Chapter, the researcher describes the methodology or approach and choice of methods to obtain and interpret information on Family Planning and HIV integration in Jamaica. This chapter will serve to provide information on the research approach, study design, including sampling, instruments, data collection, data analysis, ethical considerations for the study, and how rigour and validity were achieved.

1. Research Objectives

The objectives of this study were

1. To outline common international HIV and Family Planning integration frameworks
2. To explore the concept of integration of HIV and Family Planning within the Jamaican context
3. To assess which factors contribute to successful HIV and Family Planning integration in general and in the Jamaican context
4. To assess international best practices and provide recommendations of strategies to overcome the challenges faced in the Jamaican scenario

2. Research Approach

The methodology used a mixed-method approach which was predominately qualitative. Using a mixed-methods approach enables the researcher to combine qualitative research approaches which seek to glean a better or

clearer understanding of why things are the way they are in our social world and why people act the way they do (Myers, 1997; Hancock, 2002; Silverman, 2005) with that of the quantitative research approach which is more concerned with getting answers to questions about: how much; how many; how often; and to what extent. Qualitative research refers to the meanings, concepts, definitions, characteristics, metaphors, symbols, and descriptions of things (Berg, 2007). In contrast to quantitative research, qualitative research approaches seek to explore phenomena and as such the instruments used for this exploration use more flexible and have repetitive style of eliciting and categorizing responses to questions. Qualitative research approaches utilize semi-structured methods such as in-depth interviews, focus groups, and participant observation to gather information.

Using mixed methods involved gathering, analysing and converging both quantitative and qualitative data in the study. It also allowed the researcher to comprehend the research problem in a meaningful way (Creswell & Plano Clark, 2007). This research was conducted using an exploratory design. An exploratory design allows for the collection and analysis of qualitative data followed by quantitative data. Within the context of this research this design allowed the researcher to assess whether the qualitative themes identified were generalizable to the target population. Using this design was also beneficial due to the limited resources and time available to conduct the research. This study employed a combination of document review, interviews and an online questionnaire as the means of data collection.

3. Health Providers in Jamaica

Participants in this research consisted of HIV and Family Planning healthcare providers in Jamaica. For the purposes of this study the classification of healthcare providers was guided by that of the WHO (2006) who cited that "anyone whose focus or activity is to improve health" would be defined as a healthcare worker. This definition includes providers such as doctors, nurses and midwives, as well as technicians and managers. The WHO framework is based on the internationally standardized classification systems of the International Labour Organization (International Standard Classification of Occupations), United Nations Educational, Scientific and Cultural Organization (International Standard Classification of Education), and the United Nations Statistics Division (International Standard Industrial Classification of All Economic Activities). To this end doctors, nurses, pharmacists, social workers, and health services administrators were included.

1) Qualitative Approach

The target sample was administrators and a sample size of 2 administrators with responsibility for overseeing HIV and Family Planning Services respectively within Jamaica. They were selected as experts and key informants based on their qualifications and experience in the area being investigated. Interviewee 1 was a clinician with over 40 years' experience in the field of infectious diseases. Interviewee 1 served as advisor on pharmaceuticals and infectious diseases to the Jamaican Ministry of Health (MOH) and is the first National HIV/AIDS Staff Trainer for hospital and laboratory personnel. Interviewee 1 has been involved in the training of

medical, nursing and paramedical students and STI/HIV related research over the last ten years. Interview 1 has worked with the MOH at both the operational and policy levels.

Interview 2 was a nurse by profession with 27 years of experience in family planning, reproductive and maternal health. Interviewee 2 has had extensive training and experience in lecturing and clinical teaching of nurses, nursing students and other health personnel. Interviewee 2 currently holds a senior position within the Jamaica MOH with responsibility for the coordination of the nation's Family Planning response.

2) Quantitative Approach

The target sample was Jamaican healthcare providers drawn from a database provided by the Caribbean HIV/AIDS Regional Training (CHART) Network which is a regional non-governmental organization established for the purpose of providing capacity development among health care providers in the prevention of HIV/AIDS and in the care, treatment and support of persons living with HIV and AIDS. From the database, 108 Jamaican participants were selected as targets for this research. The composition of this sample was 63% female and 37% male with 22% doctors, 34% nurses, 11% pharmacists, 5% lab technicians, 7% social workers, 5% peer/treatment counsellors, 4% administrators and the remaining 12% representing others. The sample reflected that the majority (51%) of participants had 6-20 years of professional experience with 22% having in excess of 21yearsprofessional experience.

The participants were contacted by email and asked to complete the attached questionnaire after which they were to email the completed questionnaire back to the sender. To ensure confidentiality and encourage questionnaire completion it was made clear to participants that any information disclosed would be anonymous and names of health facilities or health providers would not be included in study.

3) Data Collection Instruments

1. Document Review

A wide range of written material was evaluated and utilized as a means of producing qualitative information to establish common practice and themes. Document review is a discreet and inexpensive means of gathering data from existing documents and was used in this study to determine trends in policy integration around the world. Document analysis involves making sense out of texts and images, which help the researcher to get information to supplement other forms of data collection techniques (Creswell J. , 2003). Documents reviewed for this study came from an extensive review of secondary sources including journals, books, policy documents, scholastic articles retrieved from the internet, program evaluation reports, white papers, presentations and reports of the multi-sectorial committee established by the MOH Jamaica to oversee the integration process.

2. Interview

Interviews are one of the most common and influential methods by which to understand human beings as they provide a space for both the interviewer and

interviewee to clarify opinions and points of view through interface (Creswell J. , 2003). The interview schedule was designed by the researcher based on the findings unearthed from the literature review. It contained seven (7) questions and allowed the participants to expound on the topic of HIV & Family Planning integration. Interviews were semi-structured in nature and gave the interviewer the freedom to manage the progress of the interview, as well as use prompts to generate further discussion (Vanderstoep & Johnston, 2009). Questions asked were open-ended in nature and notes were taken systematically to enhance the analysis process.

3. Questionnaire

The questionnaire selected was Integration of HIV and Family Planning services: An Exploration of the pros and cons of integrating these services in Jamaica. It was developed by the Caribbean Health Leadership Institute (CHLI) as a means of determining the integration of HIV services in the Caribbean. It was previously used in three Caribbean countries - Dominica, Guyana and Trinidad and Tobago- among similar respondents. The instrument consisted of 21questions and was designed to capture both qualitative and quantitative data.

4. Procedures

As stated earlier the exploratory design was used; qualitative data were collected and analysed followed by the collection and analysis of quantitative data for the purpose of determining if qualitative themes generalized to the target population. The research was conducted over a three month period. The

review of artefacts spanned 6 weeks and interviews and preliminary analysis were conducted over a 3 week period. This was followed by the administration and preliminary analysis of questionnaires which took 4 weeks.

The process of obtaining primarily qualitative information in this study involved the use of purposive samples to identify specific documents and informants. Purposive sampling has been described as sampling "done with deliberate aims in mind as opposed to a random sample or one chosen purely for its convenience and accessibility" (Wellington 2000). Purposive sampling was utilized as the researcher sought to gain in-depth information from the experiences of the informants and from specific documents. The researcher utilised interviews and documentary analysis to obtain information. In the context of this research, interviews were used to explore how documents were interpreted by administrators and how these documents may relate to their practice. Through the utilization of documents to obtain data, the researcher was able to analyse and interpret the documents with respect to the assumptions made so as to determine their applicability in the Jamaican context.

Interviews for this study were conducted via Skype as the interviewer and interviewees were in different countries and different time zones. They were held with key stakeholders who were asked about their perceptions of policy change in the provision of HIV/AIDS and Family Planning services and its impact on healthcare in Jamaica.

The questionnaire utilised a convenience sampling approach. This approach was used as the participants were the easiest to recruit for the study. The participants were contacted by email and asked to complete the attached questionnaire after which they were to email the completed questionnaire back to the sender. To ensure confidentiality and encourage questionnaire completion it was made clear to participants that any information disclosed would be made anonymous and names of health facilities or health provider would not be included in study. The data gathered was coded, processed and analysed using MS Excel.

5. Study Design

As previously stated, a mixed-methods approach was utilized for the purpose of combining qualitative and quantitative data to best understand and explain the research problem. It followed an exploratory sequential design. In this design qualitative data collection and analysis is done first to build the subsequent quantitative phase. The qualitative results connected and shaped the quantitative phase in informing the questionnaire that was selected for data collection in that phase. This design allowed the researcher to explore variables and theories and select the most appropriate questionnaire to assess whether the qualitative themes generalize to the target population. It was chosen because both the researcher and the research problem are qualitatively oriented, as well as due to the fact that resources and time were limited.

6. Reliability and Validity

To increase reliability and validity in this research a number of measures were taken. Data triangulation was employed through the use of multiple and varied sources of information, and external validity were addressed through a thick description of the site (Jamaica) and the participants. Ensuring proper procedures were used during the development and execution of the interview schedule was critical to improving reliability and validity. Detailed note taking was done to ensure accurate data capture. The selection of the questionnaire also served to increase the reliability of the research. As stated earlier, the questionnaire selected had already been pre-tested, consistency in measurement proven, and used prior in three Caribbean countries with similar respondents. It was reasonable to assume that it would have the same meanings to the Jamaican respondents.

IV. EMPIRICAL ANALYSIS

1. BACKGROUND OF JAMAICA

Demographic Profile

Jamaica with a population of 2.7 million (STATIN JA, 2013) is the largest English speaking country in the Commonwealth Caribbean and the third largest country within the Caribbean Region. Jamaica is located south of Cuba and the United States and is approximately 11,000 km^2 in size. A former British Colony, Jamaica gained its independence and became a sovereign state on August 6, 1962. The island is divided into fourteen parishes, with Kingston, its capital, and Montego Bay, a major tourist destination on the North Coast.

Map of Jamaica

Figure 1 - Map of Jamaica

Economic Profile

Jamaica is currently classified as having an upper middle income economy (The World Bank, 2011); however fiscal problems in Jamaica's economy remain constant. According the UNDP, Jamaica's total public debt burden stood at approximately US$ 13.4 billion or 135% of GDP at the end of 2009. Of this amount 55% is owed to domestic creditors and the remaining 45% to external creditors (UNDP, 2010).

Table 2-Global Economic Indicators

GLOBAL ECONOMIC INDICATORS - JAMAICA				
	2008	**2009**	**2010**	**2011**
Population ('000 persons)	2 676.7	2 686.1	2 695.5	2 709.3
Population Growth (Annual %)	0.4	0.2	0.2	0.3
GDP Per Capita (Current $ USD)	4866	4457	4966	5335
GDP Growth Rate (%)	-0.8	-3.5	-1.5	-1.3
GDP Current ($ USD)	13,075,044,561	12,012,993,251	13,414,720,930	14,439,331,395
Inflation, consumer prices (Annual %)	22	9.6	12.6	7.5
Total Debt Service (%)	19.4	34.8	28.0	36.5
Total External Debt Stock ($ USD)	10,428,652,000	11,122,025,000	14,193,131,000	14,349,943,000
Net ODA Received (% of GNI)	0.7	1.3	1.1	0.4

Source: Planning Institute of Jamaica, 2012, World Development Indicators, 2012

Social Profile

Jamaica continues to maintain its High Human Development Ranking for the UNDP and as at 2012 is tied with Brazil and ranked at number 85 in terms of its human development (UNDP, 2013). In terms of the attainment of the

Millennium Development Goals (MDGs), Jamaica is expected to achieve its targets in the areas of poverty reduction, infant and child nutrition, primary education and access to safe drinking water. Jamaica is not however expected to meet its MDG targets in the area of infant and maternal mortality and it has been noted that there is a difficulty in assessing an accurate picture of the situation as health indicator surveys are only available prior to 1991 (PIOJ, 2012).

As a result of the difficult economic climate that Jamaica experiences, there is a significant portion of the labour force that remains unemployed. The latest figures for the Planning Institute of Jamaica (PIOJ) indicate that as at 2012 the unemployment rate stood at 13.7% up from the previous year's 12.6%. Additionally, there remains a disproportionally higher rate of female unemployment in Jamaica with 17.8% of females compared to 10.3% of males who are unemployed. This disproportionality in employment can be tracked as far back as 2004 (PIOJ, 2012).

Environmental Profile

Jamaica's score for ecosystem vitality on the 2012 Environmental Performance Index (EPI) was 54.36 with Jamaica ranked 63 out of 130 countries. With this score the island is considered to be a modest performer and is comparable to countries such as Cuba, Mongolia, Thailand, Mexico and the Philippines in terms of environmental performance. Agriculture has been a major economic activity of the Jamaica however by virtue of its location, topography and geology, Jamaica, is prone to several natural hazards which

have had a significant impact on economic activities, property, human welfare and natural resources.

2. HEALTH INSTUTION & PROGRAMME IN JAMAICA

According to the World Health Organization (WHO) 2000 health system ranking, Jamaica is ranked 53 out of 190 countries in terms of its health system performance and is ranked among the top six in the region and the top three in the English-speaking Caribbean (WHO, 2000). Jamaica ranks high for developing countries in the health status of its population as a result of its well-developed primary health care infrastructure. The implementation of this infrastructure can be traced prior to the 1978 Declaration of Alma-Ata. In fact the quality of healthcare provision in Jamaica and the wider Caribbean resulted in it being the first region in the world to eradicate poliomyelitis and measles (Government of Jamaica, 2009).

The delivery of health care services to Jamaica is guided by the country's Ministry of Health (MOH) and is geared towards the attainment of a number of international targets including the Millennium Development Goals (MDGs). The country has also placed health as a priority for its development which is articulated in its National Development Plan: Vision 2030 Jamaica which outlines the country's plan for achieving developed country status by the year 2030.

The MOH addresses the healthcare needs of the population through a three tiered health care delivery system, providing primary, secondary and tertiary

heath care. It is directed through a network of Regional Health Authorities (RHAs) which are responsible for health care delivery across the island. There are four RHA's which are responsible for different regions of the island: South East (SERHA), North East (NERHA), Southern (SRHA) and Western (WRHA).

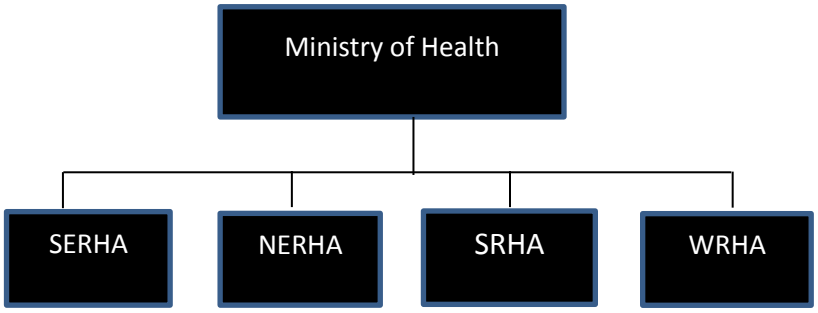


Figure 2 - Hierarchical Organization Structure of Jamaica Public Health System

There are currently twenty-three public hospitals, six specialist hospitals, ten private hospitals and 350 health centres providing a wide range of health services (JIS, 2012). It is important to note that the provision of healthcare services to citizen was provided at a cost to all except the elderly and children prior to 2008. In 2008 the Government of Jamaica abolished the charging of user fees at all public health facilities. The abolition of user fees has resulted in an increase in the number of patients accessing care with reports indicating that in the financial year prior to the introduction of the no user fee policy 1,485, 993 visits to health centres were recorded, while in 2008/09 visits totalled 1,728,570 and 1,614,246 in 2009/2010 (JIS, 2010).

Special emphasis has been placed on family planning and addressing the HIV/AIDS pandemic, as a result the National Family Planning Board (NFPB) and the National HIV/STI Programme (NHP) were established in 1968 and

1986 respectively as organs of the MOH to address those needs. These entities have been operating within the Jamaican landscape as separate entities, however in keeping with the UNAIDS 2003 Three Ones Principle, Jamaica has committed to the establishment of 'one authority' responsible for the comprehensive management of Jamaica's National HIV Response.

The UNAIDS Three Ones Principle, is a commitment by countries, multilateral and bilateral agencies, NGOs and the private sector to establish guiding principles to ensure effective coordination of national responses to HIV and AIDS. It calls for one agreed AIDS action framework that provides the basis for coordinating the work of all partners; one national AIDS coordinating authority with a broad-based multi-sectorial mandate and one agreed country level monitoring and evaluation system (UNAIDS, 2004).

It must also be noted that the integration of the two services was not only seen as a means of complying with this international commitment but was also part of the Jamaican Government's on-going efforts to reform and rationalize the public sector as a means of achieving greater efficiency, cost-effectiveness, and higher performance standards. These efforts are in tandem with the Public Sector Transformation programme undertaken by the Jamaican government in 2009. The main objective of this programme is the restructuring of the Public Sector through the introduction of new governance modalities, the rationalization and streamlining of functions across government and the implementation of new structures, systems and processes to increase productivity and cost-effectiveness within Ministries, Departments and

Agencies (MDAs) (Governemnt of Jamaica, 2011). With respect to health services, one of the outcomes of these rationalization activities was the identification of the primary health function of the government; that of providing access to basic health care, including family planning and HIV programmes. Integration of these two services is also in tandem with Jamaica's Vision 2030 development plan as it places sexual and reproductive health goals within the framework of family and population planning. Since both the HIV/STI and Family Planning programmes have the overarching goal of improving the sexual and reproductive health of the population it is therefore ideal to integrate the two for greater efficiency and coordination and sustainability.

As such the integration of HIV and Family planning is recognised as being both cost effective and in tangent with the government's primary health function. Additionally the link between HIV and STIs cannot be over-emphasised as '…HIV is primarily a sexually transmitted disease, separating prevention, care, and treatment from the sexual and reproductive health context hampers long term prevention efforts and solutions to reproductive health issues related to HIV' (The Info Project, 2006).

National Family Planning Board

The Jamaica National Family Planning Board (NFPB) was established in 1967 under the National Family Planning Act (Act No. 22 of 1970) and is

legislatively mandated to guide policy on family and population planning, as well as to act as the principal agency of Government for the allocation of financial assistance or grants to other bodies or persons engaged in the field of family and population planning in Jamaica. The NFPB has led inter-agency groups and guided policies targeting the sexual and reproductive health of males, females and adolescents. Additionally it has commissioned the National Sexual and Reproductive Health Survey enabling the organization to become the authority on SRH statistics for Jamaica. The NFPB also analyses SRH data and conducts follow-up research through its research unit on a number of critical policy issues, including gender-based violence and HIV prevalence. The NFPB achieved its mandate by establishing family planning clinics in selected communities while increasing access to family planning services in already established health service points – clinics, health centres and hospitals. During the 1970s and 1980s the NFPB became the Government agency responsible for preparing, implementing, coordinating, and promoting family planning services in Jamaica and began a scheme for the commercial distribution of condoms and oral contraceptives. Such is the success of the NFPB's programmes that the fertility rate of Jamaica has been reduced from a high of 4.5 in 1975 to a low of 2.4 in 2008 (National Family Planning Board of Jamaica, 2013). Such is the importance of family planning to the Jamaican public that a total of 313, 260 visits were made to the various family planning clinics across the island during 2010. The activities of the NFPB have continued to net positive outcomes and have resulted in Jamaica

registering a modest 0.3% growth rate in its population, and a 5% decline in estimated births for the year 2010 when compared to the previous year.

National HIV/STI Programme

The National HIV/STI Programme (NHP) was established in 1986 with the goal of leading the National HIV/AIDS response. It achieves its mandate through a series of initiatives aimed at preventing the spread of new HIV infections, providing treatment care and support to those affected by the virus, helping to create an enabling environment for the provision of services for those most at risk for infection, and implementing policies aimed at mitigating the socio-economic impact of HIV/AIDS. It is estimated that there are approximately 30,000 persons living with the epidemic and 1600 persons who died as a result of AIDs in Jamaica (UNAIDS, 2013). Through the work of the NHP, Jamaica has been able to reduce its HIV prevalence rate of over 2% in the 1990's to the current rate of 1.8% as at 2011.

It is important to note that the NHP functions as a unit of the Health Promotion and Protection Division of the Ministry of Health as it has no separate legal status and utilises a multi-sectorial approach to mobilize donors, government entities, civil society organisations and coalition groups around the goal of reducing HIV transmission in Jamaica. The NHP has operated largely as a vertical programme since its inception due in part to donor policies that require a clear distinction between resources provided for HIV

activities from that of other sources of funding. Limitations have also resulted from the need to identify and to measure the direct impact of each donor's contributions on programme beneficiaries. This has required thematic compartmentalization of various initiatives and their assigned resources. The NHP achieves its mandate through financing from the Government as well as by several external sources, including the World Bank, the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and the United States Government.

3. KEY FINDINGS

This chapter serves to present the results from the study of the effectiveness of Family Planning and HIV integration in Jamaica, with findings presented based on the research objectives. Qualitative findings are presented and quotations are used to give context to findings while quantitative results are presented in tables and charts.

The objectives of this study were

- To outline common international HIV and Family Planning integration frameworks
- To explore the concept of integration of HIV and Family Planning within the Jamaican context
- To assess which factors contribute to successful HIV and Family Planning integration in general and in the Jamaican context
- To assess international best practices and provide recommendations of strategies to overcome the challenges faced in the Jamaican scenario

Document Review

Results from the document review have indicated that integration of Family Planning and HIV services has been successfully implemented in several countries. It is of note that integration of these two services has been undertaken in different ways based on specific country need; however

commonality in outcomes as a result of integration has been found. The document review has identified these commonalities as laid out below.

1. **Client Satisfaction** is one commonality that has been found to occur as a result of Family Planning and HIV integration. Through the provision of a relatively broad range of services within one clinic or by means of a single visit to one provider has been assumed to increase client's satisfaction (Church & Mayhew, 2009).Examples of this were found in Ghana (2003), Zimbabwe (1999), Kenya (1999), South Africa (2000) and Cote d'Ivoire (2003) where clients cited appreciation at the ability to access a broader range of the Family Planning and HIV services. Similarly client satisfaction has been reported as a result of integration of HIV and Family Planning services in Cambodia (2004, 2006), Ethiopia (2006), Kenya (2008), South Africa (2006) and the Dominican Republic (2006).Examples of client satisfaction resulting from HIV and Family Planning Integration have also been found East Africa where communities perceived that integrated services were a more comprehensive response to their needs (Askew & Maggwa, 1998). Client satisfaction was also said to increase in findings from Brazil, Thailand and Vietnam where clients were said to appreciate the high quality of integrated services offered and the addition of STI services were none were previously offered (Dehne, Snow, & O'Reilly, 2000).
2. **Reducing the un-met need for family planning** is another commonality found during this research. The provision of integrated

Family Planning and HIV services has been found to reduce the incidences of unintended pregnancy and the sexual transmission of HIV both resulting from unprotected sex. Additionally, studies have also shown that integrated services have resulted in increased contraceptive use among HIV-positive women who want to prevent or delay births (Duerr et al. 2005; Chabikuli et al. 2009; Kosgei et al. 2011; Searing et al. 2008). Studies in Kenya (2013) have also shown that integrating family planning services into HIV care is associated with increased use of more effective contraceptive methods.

3. The **expansion of services to non-traditional/underserved population** has also been found to occur when Family Planning and HIV services are integrated. Integration has been found to expand access to comprehensive services regardless of the of entry point into the health care system. Additionally, through increasing the number of health facilities that provide integrated services, has resulted in key affected populations – men, sex workers and young people- being reached more effectively. An example of this can be found in research from Cambodia which revealed that through integration there was an overall increase in client visits with men accounting for 13% of these new clients (Best, 2004). The Aastha Project in India offers another example to highlight the successful integration of Family Planning and HIV/STI services. As at 2008, 38% of the estimated target population of 30,000 sex workers have accessed clinic services since integration (Family Health International, 2010).

4. **Reduction in stigma and discrimination and breaches in confidentiality and privacy** have also been attributed to Family Planning and HIV integration. Integration of services is believed to reduce STI/HIV related stigma and discrimination for clients. This is as a result of the provision of HIV services not being associated with STI/HIV care as a stand-alone services as an integrated service delivery incorporating HIV services as one of many core service areas within a facility (Johnson, Varallyay, & Ametepi, 2012).Further a study in Kenya, Malawi, and Swaziland of service integration found that stigma was reduced for women living with HIV when they received sexual and reproductive health services, including family planning, at the same facility where they received their HIV services (The Population Council, 2013).
5. **Reduction in unwanted pregnancies** is also an issue of commonality that is addressed through Family Planning and HIV integration. A 2004 study conducted among eight African countries -Botswana, Cote d'Ivoire, Kenya, Rwanda, Tanzania, Uganda, Zambia, and Zimbabwe- indicated that by integrating Family planning and HIV services, double the number of HIV positive births could be averted through the prevention of unwanted pregnancy. Another example highlighting the success of integration was found among PEPFAR recipient countries and showed that through integration, a wide range of HIV-positive births have been prevented- 178 in Guyana and 120,256 in South Africa (Population Reference Bureau, 2009).

6. **Increased financial benefits through cost-savings** have also been a result of integration. By integrating Family Planning and HIV services, cost savings from averting unintended HIV-positive births amounted to between $26,000 in Vietnam to $2.2 million in South Africa (Wilcher, Petruney, Reynolds, & Cates, 2008). Another study from India (2007) reported that when services were integrated, programme revenues exceeded programme costs and a small net profit was realized. A recent five-year study examining the cost, quality, health benefits and stigma reduction of integrating HIV programs and sexual and reproductive health service programs in Kenya, Malawi, and Swaziland found that integrated services were also found to result in savings in both time and money (Feminist Majority Foundation, 2013).

Commonality was also found in the challenges that affect the successful integration of Family Planning and HIV. These challenges include:

1. **Organizational effectiveness** has been cited as hindering successful integration. This has manifested itself as a result of problems with procurement and ensuring continuity of necessary STI/HIV supplies, staff and training to facilitate proper integration of services. Other issues such as a lack of sustainable funding limited competent medical staff and increased workloads have also been cited as affecting integration efforts in Sub-Saharan Africa (Druce & Nolan, 2007).

2. **Shortage of Human Resources** has also been found to affect integration activities. It has been argued that HIV and Family Planning integration may exacerbate workforce shortages as integration will demand an increased pool of skilled health workers, which requires both additional resources and also a significant amount of time for training (Grepin, 2011). The reality faced by developing countries and in Sub-Saharan Africa in particular, which makes integration that much more difficult is that trained health care personnel particularly physicians and nurses often leave their jobs for private sector positions or for jobs in developed countries (Maynard-Tucker, 2009). An example of this phenomenon can be found in Rwanda where it has been reported that doctors are leaving the public sector to work in the NGO sector as the salary received is six times that of the public sector (Foster & Gottret, 2006).
3. **Lack of legislative framework** has also been found to challenge HIV and Family Planning integration. The adoption of enabling policies, national strategies, and guidelines in favour of integration is necessary to drive implementation; however in some instances these have not been adequately implemented. A review of 16 countries found that policy-making processes are still mainly managed and implemented separately and the lack of coherence in operational guidelines often result in inconsistences (Druce & Nolan, 2007). Examples of this can be found in Malawi (2005), Kenya (1998) and

Zambia (1998) where a lack in adequate legislative framework for ensuring service has made integration difficult.

4. **Funding Mechanisms** are considered a major challenge to HIV and Family Planning integration. Both international funding and local government health structures still tend to be managed separately. This categorical funding of HIV and family planning services presents an operational barrier to integration and often results in a lack of coordination between departments, which serves to hamper efforts at integration. Donor institutions such as PEPFAR and the Global Fund have been slow to relinquish the vertical orientation of funding mechanisms for HIV and reproductive health, which in turn has impeded efforts to integrate these services. For example, while PEPFAR programmatically supports the integration of Family Planning and HIV services, it nonetheless prohibits the use of its' funds for purchase of contraceptives for women in HIV care, treatment, and PMTCT programs (Boonstra, 2011).

Interview

To explore the concept of integration of HIV and Family Planning within the Jamaican context.

To capture this information an interview schedule was prepared and two key stakeholders were invited to give their views on integration of HIV and Family Planning within the Jamaican context. Only one of the two

stakeholders was interviewed as scheduling issues prevented the second interviewee from participating.

It was important to get an understanding from stakeholders what they understood integration to mean. The interviewee understood integration to mean '*simply, it is services being available and accessible at all levels of care, and to include delivery at primary health care facilities.'* The interviewee highlighted that Jamaica's fight against the HIV epidemic was steered by the government-led National HIV/STI Programme (NHP) and its multi-sectorial partner, the National AIDS Committee (NAC), a civil society-led partnership group which was established to broaden participation and advise Government. When asked whether integrating the NHP into Family Planning or another health service at its inception had been contemplated, the interviewee responded *'...the NHP has operated largely as a vertical programme since its inception, due in part to donor policies that required clear distinction between resources provided for HIV activities from that of other funding sources.'*

The interviewee highlighted the Jamaica's Vision 2030 for developed nation status, noting that the policy document placed sexual and reproductive health goals as '*part and parcel*' of the framework of family and population planning. It was further cited that Family and Population Planning involved the control and management of sexually transmitted infections such as HIV/AIDS and promoted a broad-based, development-oriented analysis of the impact of such issues on families and populations. Accordingly *'...since both the HIV/STI and Family Planning programmes have the overarching goal of improving*

sexual and reproductive health of the population it is possible to integrate the two and be consistent with the current global thrust.' The interviewee made the point that Jamaica was not just now experimenting with HIV and Family Planning integration. Note was made of the previous integration attempts, the first being the integration of HIV and STD prevention at clinical and community centres in 1993 followed by a larger attempt in 2003 to integrate family planning/maternal and child health with STI/HIV service.

When asked about the process towards the integration of the two services, the interviewee explained that the plan was seen as a progression of the integration process that had been on-going for some time and that the increased pace of the integration was a result of a combination of things. The interviewee opined that Jamaica's commitment to the 'Three Ones' principle, the current attempts to streamline and modernize government and the financial realities that face the country made the decision a wise one. The interviewee explained that determining the integration of HIV and Family Planning services was arrived at by the establishment of a steering committee. The committee was comprised of key multi-sectorial stakeholders who explored the inputs and process of integration. From the discussions of this committee a framework to define integration in the Jamaican context was developed. Integration was defined as combining components of Family Planning/Reproductive Health and HIV services that are currently separate, with the goal of maximizing coverage and health outcomes for the client and optimizing the wise use of scarce resources.

The researcher was interested in whether the incremental approach was the best method going forward to achieve HIV and Family Planning integration. The interviewee was candid in response and noted

> *'...you can't divorce, you can't ignore, the difficult financial constraints that Jamaica has faced, that Jamaica continues to face, approaching integration any other way is just not feasible. Scrapping what we have done and starting over is not feasible, we just don't have the resources. But even if we had unlimited resources financial or otherwise, the fact is integration has been challenging due in large part to the history of the epidemic and the myths related to the mode of spread and stigmatization and discrimination.'*

The issue of stigma and discrimination and its effect on the integration process was also an area of discussion. The interviewee acknowledged that this was an issue and that it had to be handled delicately as there was already a high level of stigma and discrimination around the HIV population. The interviewee felt that integration '*may perpetuate stigma and discrimination because of differences in belief systems, values, organization culture and so on.'*

Questionnaire

The questionnaire was sent to 108 health professionals and the response rate was 67%. This response rate is significant allowing for increased confidence in the responses received. In addressing integration the researcher sought to

establish the respondents' understanding of the term "integration of services". Three definitions were provided and 59% selected the following:

The management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system.

It was important to ascertain the respondents' view of the appropriateness of the current placement of the National HIV/AIDS Programme and the National Family Planning Board. 82% indicated that they were appropriately placed, 13% said no and 5% said they were unsure. 58% of respondents indicated that they were in favour of HIV integration however they cautioned against implementation without the infusion of significant capital to ensure successful roll out. The majority indicated an awareness of some forms of integration of these services currently in Jamaica and acknowledged the long term implications of full integration. Of note was their overall lack of awareness of research in this area or the effectiveness of HIV/AIDS and Family Planning services as demonstrated by other countries or organizations (see Table 3). The data showed that only doctors and administrators responded in the affirmative in this regard.

There was general consensus that HIV services were currently provided on a stand-alone basis with treatment sites being centralized. They also indicated that the population most at risk was reluctant to access treatment and care services. In relation to Family Planning services there was agreement that while access to services was widespread in urban areas, this was not the case

for rural Jamaica. It was stated that more needed to be done in terms of addressing family planning issue for adolescents based on the high rate of teenage pregnancy that still persists.

Table 3- Views on Integration

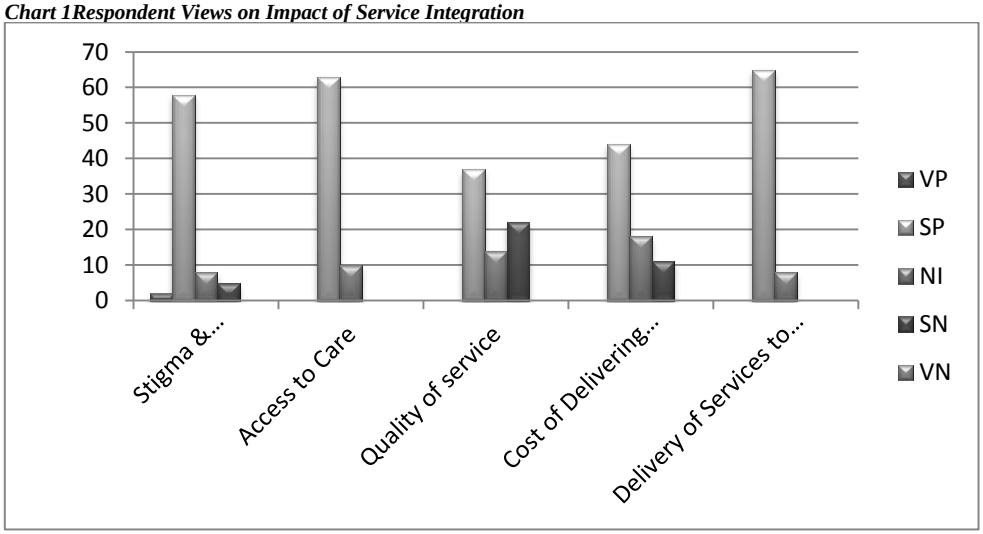
Questions	% Yes	% No	% Not sure
Are the National HIV/AIDS Programme and National Family Planning Board housed in the appropriate ministry or agency?	*82*	*13*	*5*
Are you aware of any form of integration of HIV/AIDS and Family Planning services in your country?	*69*	*31*	
Are you aware of any country, organization, group or individual that has been able to determine the cost effectiveness of integrating HIV services with existing Family Planning services?	*21*	*59*	*20*
Would you encourage or support the integration of HIV/AIDS Services with Family Planning?	*58*	*13*	*29*
Should service users be involved in the decision to integrate or not integrate HIV/AIDS and Family Planning services?	*34*	*58*	*8*
Do you think there are long term implications for the integration of HIV/AIDS and Family Planning services?	*78*		*22*
Are you aware of any research studies on the integration of HIV/AIDS and Family Planning services?	*15*		*85*

Views on the impact of HIV/AIDS and Family Planning service integration across a number of areas reflected that the respondents thought it would be mostly positive (see Chart 1). They were most optimistic about its impact on access to care, service delivery to young people, and addressing the issues of stigma and discrimination. Of note was the spread in the views on its impact on quality of service. While 51% indicated that the impact would be somewhat positive, 19% thought there would be no impact while 30% indicated the impact would be somewhat negative. However, respondents cited that integration would enhance service delivery in terms of increased

access to HIV, Family Planning and Sexual Reproductive Health as well as the convenience and affordability for clients.

When asked about where they thought HIV/AIDS services could best be integrated 44% stated Family Planning Services, 34% Primary Healthcare, 16% any other and 6% all healthcare services. As it related to having an integrated 'one-stop' model for delivery of HIV/AIDS and Family Planning services, 78% saw this approach as somewhat practical and 22% seeing it having no effect. A small percentage of the total respondents (13%) indicated that they would not encourage or support integration of these services. They stated that these services should remain as stand-alone offerings.

Chart 1Respondent Views on Impact of Service Integration



Key: VP- Very Positive SP- Somewhat Positive NI – No Impact SN – Somewhat Negative VN – Very Negative

Many respondents indicated that HIV and Family Planning integration would be best implemented on a phased based to allow for immediate correction of

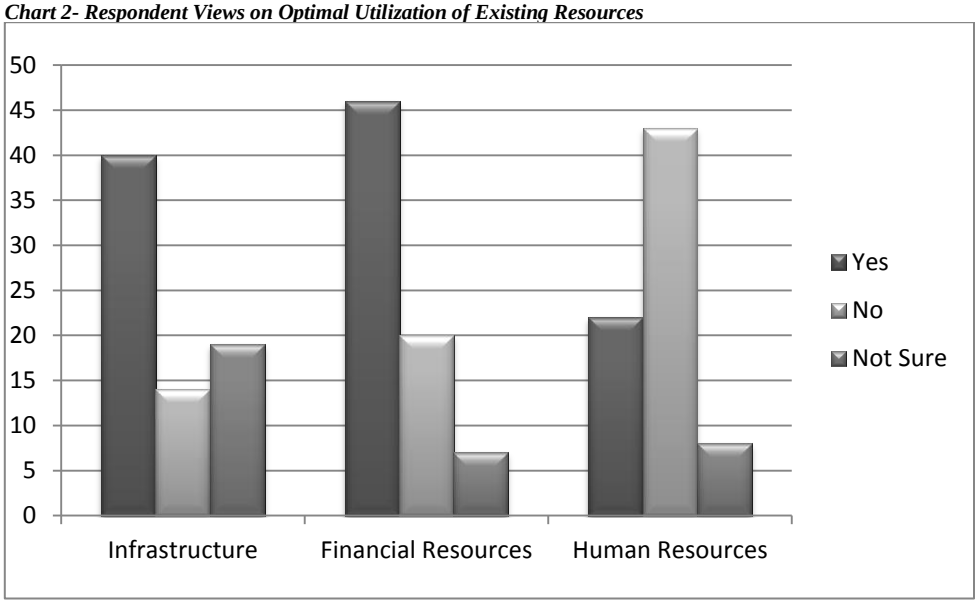
deviations and unforeseen events which can be quite costly for full scale implementation if not addressed in the short-term. They were also mindful of the fact that HIV and Family Planning integration could adversely affect quality of care and compromise the gains made in stigma and discrimination reduction, through the mergers of organizations and departments that would result from integration.

A summary of the pros posited by respondents for HIV and Family Planning integration included: efficient use of resources; development and growth of employees/staff resulting from new skills acquisition, training and the assumption of new roles, tasks and responsibilities; strengthened leadership skills resulting from coordination, opportunities to prevent new HIV infections, especially among infants and youth; access to a combination of HIV and Family Planning services that allows for convenience as a result of a 'one-stop shop'; opportunities for promoting dual protection against unintended pregnancy; improved coverage of key populations and reduced burden of care-seeking for individuals.

Respondents also highlighted what they viewed as disadvantages that could arise from HIV and Family Planning integration. The disadvantages cited included increased human resource management costs, marketing and monitoring and evaluation to include but not limited to: redeployment of staff, training and development, revision of job descriptions, public education, revision of mission, vision, branding of products and services, and revised performance monitoring and evaluations systems and tools.

When asked to rank key elements for sustainable HIV and Family Planning services integration in terms of importance, the results were as follows: 1)Funding 2) Policy change 3) Training 4) Personnel and 5) Public Education. 65% indicated that donor funding mechanisms may facilitate the integration of these services especially in light of the fact that donors were themselves pushing for integration. Their views on whether or not integration will result in more optimal utilization of existing resources are shown in Chart 2. They were most positive about how the financial resources would be optimized but showed significant concern as it related to the use of human resources.

Chart 2- Respondent Views on Optimal Utilization of Existing Resources



While the majority of the respondents viewed integration of HIV/AIDS and Family Planning services as a net positive in terms of access, delivery, administration and quality of service, only a minority indicated that the service users should be involved in the decision of whether or not these services should be integrated. 58% stated that the users should not be

involved, while a further 8% stated that they were not sure if the users should be involved.

V. SUMMARY & POLICY IMPLICATIONS

1. Summary

This study has provided evidence of the effectiveness of family planning and HIV integration and the prospects for this type of integration in Jamaica. Integration is a process that calls for consensus, and reaching consensus in and of itself is a process. It requires compromise, commitment of time, treasure and human resources, and most importantly, political will. Policy integration is critical to a unified national approach to Family Planning and HIV/AIDS service implementation and delivery for the purpose of achieving improved, sustainable, sufficient and efficient public health.

This study utilized a mixed method approach to examine and explore the effectiveness of Family Planning and HIV Integration in Jamaica. This chapter will provide a summary of the major findings, outline policy implications for integration based on these findings, and implications for future study.

The objectives of this study were: to outline common international HIV and Family Planning integration frameworks; explore the concept of integration of HIV and Family Planning within the Jamaican context; assess which factors contribute to successful HIV and Family Planning integration in general and in the Jamaican context; and to assess international best practices so as to provide strategy recommendations to overcome the challenges faced in the Jamaican environment. The findings provide evidence with respect to the

effectiveness of integrating Family Planning and HIV services, the views of healthcare providers on the issue of this type of integration in Jamaica, and serves to contribute to the existing literature on the experience of HIV and Family Planning integration in developing countries.

The methodology which guided this research called on the use of document reviews, an interview and questionnaires. The document review served to examine the extent to which integration had been achieved in other countries as well as the commonalities in both the success and challenges faced as these services were integrated. Feedback was solicited from stakeholders within the Jamaican health sector through the use of the interview and questionnaires to gauge the progress towards integration as well as the receptiveness of healthcare providers to integration within Jamaica.

The findings from this research reveal that the concept of integration of Family Planning and HIV services is in keeping both with the global trend towards strengthening the link between Family Planning, HIV/STI and Sexual and Reproductive Health; as well as with Jamaica's own Vision 2030 national development plan which places sexual and reproductive health goals within the framework of family and population planning. Additionally the findings also reveal that benefits to be derived from integration –increased client satisfaction, expansion of services, reduction in unwanted pregnancy, and cost savings - as evidenced in other countries that have embarked on Family Planning and HIV integration, are mirrored in Jamaica.

While these findings reflect positively for the possible effectiveness of Family Planning and HIV integration in Jamaica, it is important to critically examine the policy implications of these findings to determine the feasibility of implementation within the Jamaican context. The theoretical framework laid out for this study was grounded in rational planning methodology (Herbert Simon, 1960) and incrementalism (Charles Lindblom, 1959). This framework will also form the basis for addressing the policy implications as some areas of the integration process will benefit from the application of a rational planning methodology and others from the incrementalist perspective.

2. *Policy Implications*

A number of policy implications have arisen as a result of the findings of this research that speak to effective policy integration. As was previously stated integration was understood to mean '*…services being available and accessible at all levels of care, and to include delivery at primary health care facilities'* and while this understanding reflects the nature of integration, there are several steps that need to be taken to achieve this goal.

i. Establishment of a legislative framework for integration

At the forefront of the integration of these services is the need for the development of a strong legislative framework. Simply put, it is the creation of rules that establish overarching procedures to shape deliberation and future decision making for the smooth operation of the sector. While it may likely be a collection of acts, codes of practices and regulations under a general law,

it states clearly the roles, responsibilities and remit of those involved. As has been highlighted in the findings it is important to have a legislative and policy framework that consistently supports and encourages integration. Some studies reviewed for this research indicate that an absence of strong legislative framework for the integration of these services will result in a lack of coherent operational guidelines. Two examples that highlight the need for strong legislative framework can be found in Kenya (1998) and Zambia (1998). Both countries implemented integrated services which allowed nurses to legally administer STI drugs under certain conditions. However the required legislative framework used to guide primary level treatment by nurses had not been updated thus hindering implementation (Lush, 2002).

Both Family Planning and HIV services in Jamaica have been managed and operated separately, and are each governed by their own varied policies. In addition to the National Family Planning Act (1970) which governs family and population planning, Jamaica also has a number of policy documents that seek to guide the approach to addressing the HIV/AIDS crisis. These policy documents include the National HIV/AIDS Policy 2005, the National Workplace Policy of HIV/AIDS, 2010, the National Policy for HIV/AIDS Management in Schools, 2001 and the Tourism Sector HIV/AIDS Workplace Policy which all serve to guide Jamaica's HIV/AIDS response. However, despite the existence of these policies, there still remains an absence of a legislative framework in Jamaica to support the integration of Family Planning and HIV services. This concern was voiced by the interviewee in this study.

A recommendation to address this implication is to develop the necessary legislative frameworks guided by the experience from other countries, the realities of the Jamaican situation and the already existing policy. The key principle that should underlie this framework should be to protect and improve public health through the sustainable, sufficient and efficient provision of HIV/AIDS and Family Planning services to the Jamaican population. This process would benefit from the use of the rational planning approach to examine all available policies (e.g. National HIV/AIDS Policy), inputs and their attendant costs (e.g. service provision and procurement of drugs) to determine the most appropriate approach for the Jamaican environment. Therefore through the development of a strong legislative framework, policymakers will determine the policies and protocols that need to be modified from existing policy and/or create new ones to facilitate and guide the integration process (Farrell, 2007).

ii. Funding

Findings from the review of literature, document review as well as online questionnaires all indicate that through integration there is an increase in access to care and broader coverage of people living with HIV. While this is the intended outcome of integration, funding to meet the increased demand now becomes an issue of concern. Funding is one of the most critical determinants of any health system as it serves to define the structure, the behaviour of different stakeholders and quality of outcomes. As has been noted previously, Jamaica's HIV response is primarily donor financed with significant resources coming from the World Bank, the United States, and the

Global Fund. However with the reclassification of Jamaica as a middle income country by the World Bank in 2012, difficulties have been experienced in accessing resources from these international donor agencies. This has in turn meant that Jamaica has had to increase its budget in this area despite its fiscal limitations.

Policy-makers must therefore in drafting new Family Planning and HIV integrated policy, understand that financing of the integrated service must be addressed. A rational planning approach to this issue should be considered as a means of assessing the allocative efficiency of existing HIV and Family Planning interventions to allow for comparisons to be made between the outcomes and financial consequences of different interventions. This lays the foundation for incremental integration of these policies. It has been noted that integration can lead to economic benefits arising from cost savings both administratively and in clinical areas (Coburn, 2001). However it has also been argued that the process of integration may initially result in increased costs before they provide savings (Coburn, 2001). Therefore policy makers must consider the way services are funded in light of integration. Additionally, in light of integration, policy regarding financing mechanisms that allow pooling of funds across services that were previously differentiated must now be considered.

iii. Human Resources

Another policy implication that was identified as a result of this research is that of the effects of Family Planning and HIV integration on human

resources. Both respondents in the questionnaire and findings from the document review indicate that human resources are critical to the success of integration at all stages as they will both impact and be impacted by integration. While findings from studies in the document review (Maynard-Tucker, 2009; Foster & Gottret, 2006) highlight the challenges of finding skilled health workers who will remain in the public service, and the questionnaire respondents highlighted the positives of gaining new skills and knowledge and improved efficient service delivery as a result of integration, both scenarios have to be addressed.

For integration to be successful retraining of existing healthcare providers will have to be undertaken, coupled with an increase in the numbers of healthcare personnel to meet the expected increase in demand for service arising from integration. Integration will result in the redeployment and rationalization of human resources both administratively as well as amongst healthcare providers and will also call for a merging of roles, responsibilities and positions. These changes call for the development and implementation of effective policy geared towards change management which would ensure that changes are institutionalized incrementally.

Implications for future study

While this research aimed to address all its objectives, there were limitations to the study that did arise. One of the primary limitations of this study was the small interview sample size. While the participants who were targeted met the study criteria, including more stakeholders would provide additional

information and opinions on the areas being investigated. Perhaps the most important limitation that this research faced was the distance and time difference. Due to the differing time zones there was a 14 hour difference to contend with which made contact between the researcher and stakeholders a challenge. Scheduling conflicts and other unforeseen circumstances resulted in one of the two stakeholders not being interviewed. Due to time constraints the researcher was unable to find a suitable replacement.

This study was undertaken at a time when Jamaica was refocusing its efforts on Family Planning and Integration and while it has provided insights that can guide Jamaica through this process, there remains much more to be investigated and understood. It was interesting to note that respondents in the study felt that service users should not be involved in the decision of whether or not services should be integrated. It would be instructive to examine the reasons for this as well as determining from service users their feeling and attitudes towards integration.

Research can also focus on the effect that stigma and discrimination has on both the healthcare provider and recipient in light of integration. This issue would be of extreme importance because of the existing stigma and discrimination that is felt among the HIV population prior to integration.

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Appendix

Key Stakeholder's interview schedule

Exploring the effectiveness of Family Planning & HIV integration in Jamaica

Interview Schedule

1. What are the functions of the Jamaica National Family Planning Board (JNFPB) and National HIV/STI Programme (NHP)?

2. Was the NHP envisioned to operate as separate entity as its establishment?

3. Does Family Planning and HIV integration factor in Jamaica's development?

4. Is the incremental approach the best method to achieve HIV and Family Planning integration?

5. In light of the country's financial situation, why is the integration being contemplated at this time?

6. What phase in the integration process is Jamaica at?

7. How would integration impact Stigma & Discrimination?

Questionnaire

INTEGRATION OF HIV AND FAMILY PLANNING SERVICES: An Exploration of the pros and cons of integrating these services in Jamaica

Thank you for taking the time to complete this survey.
Your name will not be placed on this survey. You don't have to answer any question you don't want to and the answers you provide will not be shared with your facility or anyone in your workplace. Please circle the answer that you choose.

Practicing Profession:

Doctor - Nurse - Pharmacist – Lab Technician – Social Worker -

Peer/Treatment Advocate - Administrator - Other -

Years of Professional Practice: < 5 6 – 10 11 -15 16 – 20 >21 - 24

Facility in which you work:

Hospital - Health Care Centre/Clinic – STD/Family Planning Clinic – HIV Specialty Clinic –

Pharmacy – Laboratory - Private Practice - Other –

Gender: Male - Female –

Age Range: < 25 26 – 35 36 – 45 46- 55 > 55

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1. **Do you think that the National HIV/AIDS Programme and National Family Planning Board are housed in the appropriate ministry or agency? Give reasons for your answer.**

☐ **Yes** ☐ **No - rest no response**

_____

_____

_____

_____

___

2. **How would say HIV Services are currently delivered in your country including care and treatment for people living with HIV/AIDS?**

3. **How would say Family Planning Services are currently delivered in your country?**

4. **Suggest ways in which the delivery of HIV services can be improved and maintained.**

5. **Suggest ways in which the delivery of Family Planning services can be improved and maintained.**

6. **Which of the following best express your understanding of the term 'Integration of Services?**

   a. A package of preventive and curative health interventions for a particular population group

   b. multi-purpose service delivery points – a range of services for a catchment population is provided at one location and under one overall manager

   c. The management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system

7. **Are you aware of any form of integration of HIV/AIDS and Family Planning services in your country? If yes, what stage are you? If no are there plans to do so?**

   Yes ☐

   a. Beginning ☐ **b. Middle** ☐ **c. Fully Integrated** ☐

   ☐

No

a. Yes ☐ **b. No** ☐ **c. Not sure** ☐

_____

_____

_____

8. In your opinion, how will integrating HIV/AIDS and Family Planning services impact on

(a) **stigma & discrimination**

1. Very positive 2. Somewhat positive 3. No impact 4.Somewhat negative 5.Very Negative

(*b*) access to care

1. Very positive 2. Somewhat positive 3. No impact 4.Somewhat negative 5.Very Negative

(*c*) quality of service and

1. Very positive 2. Somewhat positive 3. No impact 4.Somewhat negative 5.Very Negative

(*d*) cost of delivering HIV/AIDS Services

1. Very positive 2. Somewhat positive 3. No impact 4.Somewhat negative 5.Very Negative

Add comments below if desired.

_____

_____

_____

9. Do you think HIV/AIDS Services should be integrated into

(a) **Family Planning Services**

(b) **Primary Healthcare**

(c) **any other**

(d) **all healthcare services**

Give reasons for your choice

_____
_____
_____
_____
_____

10. Are you aware of any country, organization, group or individual that has been able to determine the cost effectiveness of integrating HIV services with existing Family Planning services? If yes, please share.

Yes ☐ **No** ☐

11. **Share what you see as the pros and cons of HIV and Family Planning services integration?**

12. **In your opinion, what are some of the major requirements for integration of HIV/AIDS Services with Family Planning?**

    a. **Rank the following in terms of importance for sustainable HIV and Family Planning services integration?**
       1. Funding
       2. Policy change
       3. Personnel
       4. Training
       5. Public education

13. **Would you encourage or support the integration of HIV/AIDS Services with Family Planning?**

Yes ☐ **No** ☐ **Not sure** ☐

Give reasons for your answers.

_____

_____

14. If you are not in support of the integration of HIV/AIDS and Family Planning services what is your preferred approach for the delivery of HIV/AIDS Services?

_____
_____
_____
_____
_____

15. How do you see the integration of HIV/AIDS and Family Planning services impacting on the delivery of services to young people?

1. Very positive 2. Somewhat positive 3. No impact 4.Somewhat negative 5.Very Negative

Add comments as desired.

_____

_____

_____

16. Do you think integration will result in more optimal utilization of existing

(a) ***Infrastructure*** **Yes _____ No _____ Not sure _____**

(b) ***financial resources*** **Yes_____ No _____ Not sure _____**

(c) ***human resources*** **Yes _____ No _____ Not sure _____**

Give reasons for your answer.

_____

_____

_____

17. How practical do you think is the integrated 'one-stop shop' model for the delivery of HIV/AIDS and Family Planning services?

1. Very Practical 2. Somewhat Practical 3. No Effect 4. Somewhat Impractical 5. Very Impractical

18. Should service users be involved in the decision to integrate or not integrate HIV/AIDS and Family Planning services?

Yes ☐ No ☐ Not sure ☐

Give reasons for your answers.

_____

_____

_____

19. Do you think donor funding mechanisms may (*a*) ***facilitate* or (*b*) ***hinder*** the integration of HIV/AIDS and Family Planning services?**

Facilitate ☐ **Hinder** ☐

_____

_____

_____

20. Do you think there are long term implications for the integration of HIV/AIDS and Family Planning services? If yes, what may be some of the major long term implications?

Yes ☐ **No** ☐ **Not sure** ☐

_____

_____

_____

_____

_____

21. Are you aware of any research studies on the integration of HIV/AIDS and Family Planning services? If yes, please share.

Yes ☐ **No** ☐

_____

_____

_____

END

Thank you for taking the time to answer these questions.

Kindly be reminded that your responses will be held in strict confidence and will only be utilized for the purpose of this study.

국문초록

자메이카의 가족계획과 HIV 통합정책의 효과성에 관한 연구

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본 연구는 자메이카의 가족계획과 에이즈(HIV) 서비스 통합정책에 대해 연구하였다. 연구목적을 달성하기 위해 통합과 관련된 도전과제들을 탐색하고 이러한 문제점을 해결하기 위한 대안들을 살펴보았다. 자메이카 의료서비스 제공자들 중 일부를 선택하여 이들로부터 가족계획과 에이즈(HIV) 서비스 통합정책에 관한 견해를 확인하였다. 자료수집을 위해서 질적 및 양적 자료를 포괄하는 혼합방법을 사용하였다. 주요 정보제공자에 대한 인터뷰, 자료조사, 그리고 의료서비스 제공자에 대한 온라인 설문조사를 실시하였다. 연구결과, 통합정책이 성공적으로 집행되면 비용절감과 서비스 제공이 확대된다는 것을 밝혀냈다. 그러나 법적토대가 취약하고 재정이 부족한 점이 성공적인 통합을 저해하는 요인이라는 점을 밝혔다. 정책적 함의로서 법적 토대를 구축하고 재정 및 인적자원을 확보하는 것이 중요하다는 점을 제안하였다.

주요어: 통합, 의료서비스 제공, 가족계획 및 에이즈 정책, 자메이카

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